STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445300	A. BUILDING _____ B. WING _____	C 09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW TERRACE OF LIFE CARE	PO BOX 26 COFFEY LANE RUTLEDGE, TN 37861

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F 000	INITIAL COMMENTS Complaint investigation #28683 was completed at Ridgeview Terrrace of Life Care on September 26, 2011. Complaint #28683 was substantiated and F-323 cited at a scope and severity level of "G" (Actual Harm) related to the facility failed to ensure a safety device (bed alarm) was in place to alert staff of unassisted transfers resulting in a fracture for resident #1.	F 000	This Plan of Correction is submitted as required under Federal and State regulations and statues applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided documentation (investigation), and interview, the facility failed to ensure a safety device was turned on to alert staff of unassisted transfers for one resident (#1) of five residents reviewed. The facility's failure to ensure the bed alarm was turned on for resident #1 resulted in a fall and a left orbital floor fracture (facial bone under the left eye) and soft tissue injury to the left orbit (facial tissue near the left eye) (Actual	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Bourgeois	Executive Director	10/10/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

OCT 12 2011

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F 323	Continued From page 1 Harm). The findings included: Resident #1 was initially admitted to the facility on August 8, 2011, with diagnoses to include Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Difficulty Walking, Muscle Weakness, Anxiety, and Dementia. Medical record review of Nursing Assessments dated August 8 and 16, 2011, revealed the resident had short-term memory loss. Medical record review of a Fall Risk Evaluation dated August 8, 2011, revealed a resident who scores ten or higher is at risk (of falls); the resident scored six. Medical record review of nurse's notes dated August 8, 9, 10, 17, 18, and 23, 2011, revealed the resident was "confused." Medical record review of two Rehabilitation Multidisciplinary Screening Tools, both dated August 9, 2011, revealed the following: (Screening #1) "...Comments: Nursing staff came to rehab gym this morning to get wc (wheelchair) for patient secondary to instability with gait and poor endurance-putting (resident) at increased risk for falls when staff was trying to assist (resident) to dining room...Cognition: poor memory, poor historian...Transfers: sit to stand with CGA (care giver assist); bed to WC with CGA...Balance and Falls:...high risk for falls...Other: visual deficits...(Screening #2) "...Comments: Pt (patient) presents with poor	F 323	CORRECTIVE ACTION: Resident #1 expired on 8/27/11. RESIDENTS WITH POTENTIAL TO BE AFFECTED: Residents with current alarm interventions were reviewed by nursing administration. Alarms will be monitored by licensed nurses for placement and to ensure they are in the "on" position using the following schedule: every hour for three days (9/26/11-9/28/11), every two hours for five days (9/29/11-10/3/11), every four hours for seven days (10/4/11-10/10/11), and every eight hours beginning 10/11/11. SYSTEMIC CHANGES: Licensed nurses were inserviced on 9/27/11 on ensuring alarms are in place and in the "on" position. MONITORING: Alarm monitoring process will be audited by Restorative Nursing/Director of Nursing/Assistant Director of Nursing. Results of audits will be presented by the Director of Nursing and reviewed in monthly Performance Improvement (PI) committee meeting for 3 months.	10/14/11

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F 323	Continued From page 2 endurance, decreased strength in UE's (upper extremities) and LE's (lower extremities), decreased balance and coordination, poor safety awareness with transfers, decreased ability to perform ADLs (Activities of Daily Living) and transfers safely...Dressing/Grooming/Bathing/Hygiene: needs assistance...Transfers: needs assistance...Ambulation: needs assistance...Balance and Falls: falls risk due to confusion..." Medical record review of a Physical Therapy Plan of Treatment dated August 9, 2011, revealed "...gait instability with increased risk for fall...poor endurance...poor balance...difficulties with gait and transfers...high fall risk category..." Medical record review of a nurse's note dated August 10, 2011, revealed "...resident in bathroom...lost balance...confused...(family) stated has low vision and can only see peripheral vision. Medical record review of a Rehabilitation Multidisciplinary Screening Tool dated August 17, 2011, revealed "...Cognition: poor safety awareness; Dementia; anxious...Transfers: sit to stand minimal assist for safety...Other: impaired vision..." Medical record review of a nurse's note dated August 16, 2011, revealed "...restless...very unsteady...redirected to bed several times..." Medical record review of a Physical Therapy Plan of Treatment dated August 17, 2011, revealed "...high risk for falls...Dementia...has experienced	F 323		

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F 323	Continued From page 3 LOB (loss of balance)...decreased strength...poor balance...difficulty with gait...difficulty with transfers...high fall risk category..." Medical record review of two nurse's notes dated August 17, 2011, revealed the following: 3:30 p.m. "...confused, mental function varies throughout the day...very forgetful...somewhat anxious, wants another person to be with her every second..." 10:00 p.m. "...increased confusion...continuously ask staff to stay in room..." Medical record review of a Physician's Telephone Order dated August 19, 2011, revealed "Bed Alarm." Medical record review of a nurse's note dated August 19, 2011, revealed "...bed alarm placed on bed for poor safety awareness..." Medical record review of a nurse's note dated August 20, 2011, revealed "...keeps getting up by self and walking to bed or bathroom, counseled many times by staff without success..." (One day after bed alarm placed) Medical record review of a nurse's note dated August 22, 2011, revealed "...anxious, wants staff to stay in room every second...short-term memory problem..." Medical record review of a nurse's note dated August 23, 2011, at 9:40 p.m., revealed "...order received for BNP (brain natriuretic peptide- a heart failure blood test) and after lab draw give 20 mg (milligrams) Lasix (diuretic to increase the rate and amount of urination) IM	F 323		

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F 323	Continued From page 4	F 323		

(intramuscular-injection into the muscle) x (times) 1 (one) dose..." Continued review revealed the lab was drawn and the Lasix was given at 11:00 p.m.

Medical record review of a nurse's note dated August 24, 2011, at 12:00 a.m., revealed "...upon entering resident's room I observed resident lying on side in front of closet with a small amount of blood coming from the head...I called out for help and instructed for someone to call 911...resident was unconscious upon entering the room...resident was rolled over to back with c-spine held in place...blood pressure and pulse were obtained...resident awake and was agitated and temperature and respirations were not obtained..." Continued review revealed 911 was called and EMS (Emergency Medical Services) arrived at the facility at 12:09 a.m., and departed from the facility to the emergency room with the resident at 12:25 a.m. Further review revealed "12:00 a.m., Addendum. Resident had a bed alarm and it was not turned on at the time of the incident."

Review of a facility investigation dated August 24, 2011, at 12:00 a.m., revealed "...Summary of Investigative Facts: resident was found lying on floor in room...admitted to hospital with hip fracture...Follow-Up:...Add-patient did not have hip fracture..." Continued review of the facility investigation revealed a witness statement by LPN #2 dated September 26, 2011, revealed "...family had been here to visit...(family) assisted resident to bed and did not turn on bed alarm..."

Medical record review of a CT of the Brain (Computed Tomography, a radiologic imaging

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F 323	Continued From page 5 that uses computer processing to generate an image of tissue density in slices through the patient's body) dated August 24, 2011, revealed "...Clinical History: fall, laceration to the left cheek, swollen left eye, headache...Impression: Findings of soft tissue injury about the left orbit (socket of the eye). There is also a fracture of the left orbital floor (fracture of the bone at the floor of the eye socket)..." Medical record review of a CT of Facial Bones dated August 24, 2011, revealed, "... Clinical History: fall, laceration to the left cheek, swollen left eye, headache...Impression: Minimally displaced fracture of the left orbital floor..." Medical record review of a Hospital Discharge Summary dated August 26, 2011, revealed "...sent over from (nursing home) after (resident) fell there...sustained a prominent hematoma (localized swelling filled with blood resulting from a break in a blood vessel) to the left periorbital region (around the left socket of the eye)...left hip and leg was externally rotated and in the emergency room thought (resident) had a left hip fracture, but...radiologist determined that there was no fracture...because of the fall and the mental status changes, CT of the brain was also done and was negative for any intracranial finding, though there was incidental finding of the soft tissue injury to the left orbit and a fracture to the left orbital floor...CT of the facial bones was done to follow up on this and confirmed a minimally displaced fracture to the left orbital floor and, of course, the soft tissue swelling around that area..." Continued review revealed the resident was admitted to the hospital's Intensive Care Unit (ICU) on August 24, 2011, improved,	F 323		

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F 323	Continued From page 6 and was discharged back to the nursing home on August 26, 2011. Medical record review of a Physician's Progress Note dated August 27, 2011, revealed "...sent to the hospital...August 24 after a fall...had a loss of consciousness with the fall...did have an orbital floor fracture..." Medical record review of a nurse's note revealed the resident expired on August 27, 2011, at 10:15 p.m. Interview with Physical Therapist (PT) #1 on September 26, 2011, at 3:25 p.m., in the Conference Room confirmed the resident was a fall risk due to confusion, poor vision, poor strength, poor muscular endurance, Dementia, and confusion. Continued interview confirmed the Rehab staff worked with the resident from admission throughout the resident's stay. Further interview confirmed the resident remained unchanged and was a fall risk due to confusion, poor vision, poor strength, poor muscular endurance, Dementia, and confusion. Interview by telephone on September 26, 2011, at 3:40 p.m., with Licensed Practical Nurse (LPN) #1, confirmed the resident was confused and LPN #1 was concerned the resident was going to fall. Continued interview confirmed LPN #1 stated "(Resident) was unsteady and I knew it was just a matter of time before (resident) fell, that's why I called the doctor and got the order for the bed alarm." Continued interview confirmed a bed alarm had been ordered and placed due to the resident's poor safety awareness to alert staff of unassisted transfers. Continued interview	F 323		

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F 323	Continued From page 7 confirmed LPN #1 entered the room on August 24, 2011, at 12:00 a.m., found the resident lying on the floor from a fall; the resident was bleeding from a laceration on the left side of the head near the left eye, and was unconscious. Continued interview confirmed upon rolling the resident over onto the resident's back, pressure was applied to the laceration, the bleeding was controlled, and the resident regained consciousness. Further interview confirmed the bed alarm was not sounding at the time of the fall and was not turned on. Interview with LPN #2 on September 26, 2011, at 4:00 p.m., in the Conference Room confirmed LPN #1 called out for help upon finding the resident lying in the floor from the fall on August 24, 2011, at 12:00 a.m. Continued interview confirmed the bed alarm in place for the resident was a pressure pad alarm. Continued interview confirmed the bed alarm was not sounding at the time of the fall and was not turned on. Continued interview confirmed a family member had been visiting with the resident, had put the resident to bed, and didn't turn the bed alarm on. Continued interview confirmed LPN #2 observed the family member leaving the facility at 10:00 p.m., on August 23, 2011. Continued interview confirmed LPN #2 failed to check on the resident or the bed alarm upon observing the family member leave the facility. Continued interview confirmed the Certified Nursing Assistants (CNAs) and Nurses (Licensed Practical Nurses and/or Registered Nurses) are required to make rounds (check on residents) at least every two hours. Further interview with LPN #2 confirmed the facility failed to check the resident's bed alarm at least every two hours and failed to ensure the bed alarm was	F 323		

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F 323	Continued From page 8 turned on at the time of the fall. Interview by telephone on September 26, 2011, at 5:05 p.m., with Family Member #1, confirmed Family Member #1 assisted the resident to bed on August 23, 2011, between 7:45 p.m., and 8:00 p.m. Continued interview confirmed Family Member #1 was unaware the resident had an alarm and stated, "They (nursing home staff) never told me or showed me anything about a bed alarm." Continued interview confirmed on August 23, 2011, at 8:30 p.m., Family Member #1 asked LPN #2 to give the resident's bedtime medications. Continued interview confirmed LPN #2 entered the room at 9:00 p.m., gave the resident's bedtime medications, and immediately left the room without checking anything on the resident's bed. Interview with LPN #2 on September 26, 2011, at 5:15 p.m., in the Conference Room confirmed LPN #2 went into the resident's room on September 23, 2011, at 9:00 p.m., and 11:00 p.m. and administered the medications to the resident (bedtime medications at 9:00 p.m., and Lasix at 11:00 p.m.). Continued interview confirmed the resident was in the bed and LPN #2 failed to ensure the bed alarm was turned on before leaving the room. Interview with CNA #1 on September 26, 2011, at 5:45 p.m., in the Conference Room confirmed CNA #1 did not recall checking the resident's alarm after family member #1 put the resident to bed on August 23, 2011. Interview with CNA #2 on September 26, 2011, at 6:00 p.m., in the Conference Room confirmed	F 323		

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F 323	Continued From page 9 Family Member #1 was in the resident's room and assisted the resident to bed on the evening of August 23, 2011. CNA #2 confirmed checking on the resident's roommate, but did not check on the resident. Continued interview confirmed CNA #2 stated "(resident's name) was sleeping; I did not check the resident or bed alarm because (Family Member #1) was with the resident." Interview with CNA #3 on September 26, 2011, at 6:15 p.m., in the Conference Room confirmed CNA #3 did not recall checking the resident's alarm on August 23, 2011. Interview with the Assistant Director of Nursing (ADON) on September 26, 2011, at 6:35 p.m., in the ADON's Office confirmed the facility staff was unaware the resident had a fracture and stated "We thought (resident) had a hip fracture, but it was negative; we didn't know there was a fracture." Continued interview confirmed the facility failed to review hospital documentation thoroughly and the unassisted transfer out of bed resulted in a fracture. C/O 28683	F 323		